

# **EXHIBIT L**

1 IN THE UNITED STATES DISTRICT COURT  
2 FOR THE SOUTHERN DISTRICT OF WEST VIRGINIA  
3 CHARLESTON DIVISION

4 IN RE: ETHICON, INC., PELVIC :Master File No.  
5 REPAIR SYSTEM PRODUCTS : 2:12-MD-02327  
6 LIABILITY LITIGATION :  
7 THIS DOCUMENT RELATES TO THE :  
8 FOLLOWING CASES IN WAVE 2 OF :  
9 MDL 200: :  
10 PATRICIA MARTIN AND :  
11 DENNIS MARTIN, SR., :JOSEPH R. GOODWIN  
12 Plaintiffs, :U.S. DISTRICT JUDGE  
13 v. :  
14 ETHICON, INC., et al., :Case No.  
15 Defendants. : 2:12-CV-02185

16

17 June 6, 2016

18

19 Videotaped deposition of  
20 KONSTANTIN WALMSLEY, M.D., held at COURTYARD  
21 MARRIOTT WEST ORANGE, 8 Rooney Circle, West  
22 Orange, New Jersey, before Margaret M. Reihl,  
23 RPR, CCR, CRR, CLR and Notary Public, on the  
24 above date, commencing at 9:04 a.m.

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I N D E X

2 WITNESS:

Page

3 KONSTANTIN WALMSLEY, M.D.

4 By Mr. Griffin

4, 70

5 By Mr. Thompson

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E X H I B I T S

8

WALMSLEY-MARTIN DEPOSITION EXHIBITS

MARKED

9

No. 1 Rule 26 Expert Report of Konstantin  
Walmsley, M.D.

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No. 2 IME exam notes of Dr. Walmsley  
date of exam: 5/3/16

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1                           ... KONSTANTIN WALMSLEY, M.D., having  
2                           been duly sworn as a witness, was examined and  
3                           testified as follows ...

4     BY MR. GRIFFIN:

5         Q.     Doctor, for my name is Will Griffin, and  
6     I represent Johnson & Johnson in a lawsuit regarding  
7     Pamela Martin, and is it my understanding that you've  
8     been retained as an expert for the plaintiffs in this  
9     matter in that case?

10       A.     Yes, sir.

11       Q.     Could you state your full name.

12       A.     Konstantin Walmsley.

13       Q.     And your address?

14       A.     282 Forest Avenue, Glen Ridge, New  
15 Jersey 07028.

16       Q.     And can you tell me in the Pamela Martin  
17 case what you've reviewed?

18       A.     Yes, sir. It's enclosed in my report.

19     There are a variety of different medical records listed  
20     in the report, including Siloam Springs Regional  
21     Hospital, that's S-i-l-o-a-m, St. John Medical Center,  
22     Mercy Hospital Northwest Arkansas, International  
23     Urogynecology Associates.

24       Q.     And I don't think you need to go through

1 all of those, but were there any medical records beyond  
2 the ones that are listed here?

3 A. No, sir.

4 Q. Were there any depositions you reviewed  
5 in this case?

6 A. That's correct.

7 Q. There were?

8 A. Yes.

9 Q. What depositions?

10 A. The deposition I believe of the  
11 implanting surgeon and of the patient.

12 Q. Anything else that you reviewed?

13 A. No, sir.

14 MR. GRIFFIN: Okay. Let's mark this as  
15 exhibit.

16 (Document marked for identification as  
17 Walmsley-Martin Deposition Exhibit No. 1.)

18 BY MR. GRIFFIN:

19 Q. What I've marked as Exhibit 1, is that a  
20 copy of your opinions in this case?

21 A. Yes, sir.

22 Q. And with the addition of the two  
23 depositions that you said, does that cover all of the  
24 documents you've reviewed in relation to this

1 particular case, the Martin case?

2 A. Yes.

3 MR. GRIFFIN: Introduce that as Exhibit  
4 1.

5 BY MR. GRIFFIN:

6 Q. Dr. Walmsley, how often have you  
7 testified?

8 A. I have testified probably between 10 and  
9 20 times.

10 Q. Is that all by deposition or sometimes  
11 at trial?

12 A. There have been -- mostly deposition and  
13 a few trial appearances.

14 Q. Okay. Other than -- have they all been  
15 in mesh cases?

16 A. No, sir.

17 Q. Some medical malpractice cases?

18 A. Yes, sir.

19 Q. How many were medical malpractice cases?

20 A. Perhaps five to six.

21 Q. And that would leave the other 15, 10 to  
22 15 being mesh cases?

23 A. Yes, although that 10 to 15 might be a  
24 bit of a generous estimate, in retrospect.

1 Q. And what companies have you testified  
2 against in mesh related litigation?

3 A. Today's obviously, Bard, Boston  
4 Scientific.

5 Q. And about how much have you made from  
6 testifying in mesh cases and reviewing cases related to  
7 mesh?

8 A. I probably received on the order of 40  
9 to \$50,000.

10 Q. Have you implanted TVT devices?

11 A. I have.

12 Q. Have you implanted TVT-O devices?

13 A. I have not.

14 Q. Have you had any training in the  
15 implantation of TVT-O devices?

16 A. Yes, sir.

17 Q. Where did you obtain that training?

18 A. In my fellowship and in a workshop soon  
19 after I finished my fellowship.

20 Q. Beyond -- was that a cadaver workshop?

21 A. Yes, sir.

22 Q. Beyond doing it on a cadaver, have you  
23 ever done a TVT-O on a human, a live human?

24 A. No, no, I've never done one primarily

1 myself.

2 Q. About how many midurethral mesh slings  
3 have you implanted?

4 A. Over my career, probably between about  
5 three and 500.

6 Q. Have you implanted mesh midurethral  
7 slings this year?

8 A. I have.

9 Q. How many have you implanted this year?

10 A. Estimate about four or five.

11 Q. Have you taken part in or published any  
12 studies related to stress urinary incontinence?

13 A. I have not.

14 Q. Doctor, if you have your report in front  
15 of you, as I understand it, Ms. Martin has had two  
16 procedures by Dr. Hill.

17 Is that your understanding?

18 A. It is.

19 Q. July 17th, 2009 was a TVT procedure --  
20 12, 2009; is that correct?

21 A. Yeah, June 12th, 2009, yes, sir.

22 Q. And on April 16, 2010 he did -- I always  
23 mess up this word -- pronounce it for me, please.

24 A. Yes, sir, it's a posterior colporrhaphy.

1 Q. Colporrhaphy, thank you.

2 In your -- between the time of the TVT  
3 operation on July 12, 2009 and the colporrhaphy on  
4 April 16, 2010, did the plaintiff, Ms. Martin, ever  
5 complain of dyspareunia?

6 A. I think you meant June 12th, 2009,  
7 correct?

8 Q. Yes. What did I say?

9 A. I thought you said July 12th.

10 Q. Okay, you're right.

11 A. No, not from my review of the medical  
12 records did I see that.

13 Q. Okay. When was the first time she  
14 complained of dyspareunia?

15 A. July 11th, 2011 is my first  
16 memorialization of that, reviewing her medical records.

17 Q. And what did she relate that to?

18 A. Well, she related it to pain with  
19 intercourse.

20 Q. But when did she say it started?

21 A. I mean, from what I recall reviewing the  
22 medical records, it started somewhat recently prior to  
23 that visit.

24 Q. Did she, in fact, state that she was

1       complaining -- she complained of dyspareunia which was  
2       present almost constantly since her posterior  
3       colporrhaphy?

4           A.       Interestingly, my recollection of that,  
5       and this is based on her September 29th visit, is that  
6       she had had this present since her TVT-O and posterior  
7       colporrhaphy, so I don't recall that specific element.

8           Q.       I'm going to show you the Martin record,  
9       Martin and it's MDR0024.

10          A.       Thank you.

11          Q.       Do you remember reviewing that?

12          A.       I did see this letter, yes.

13          Q.       Okay. In that letter dated July 19,  
14       2011, what is the time frame from which Ms. Martin  
15       dates her dyspareunia?

16          A.       Well, this -- I mean, to be fair, this  
17       is Dr. Hill's letter to Dr. Lewis in which he is  
18       stating, and I quote, "she is complaining of  
19       dyspareunia which she states has been present almost  
20       constantly since her posterior colporrhaphy."

21          Q.       Okay. And in your report, you did  
22       not -- let me see your report, in bullet point at the  
23       bottom of the page, that is not contained, is it, that  
24       it's --

1                   A.         Only insofar as I tend to rely upon the  
2                   actual medical record and office visit material to some  
3                   degree more than a letter to a colleague, I did not.

4                   Q.         Okay.  MDR0004 of the Martin, Chad Hill  
5                   records from Siloam Springs.

6                   A.         This is July 19, 2011.  I see this,  
7                   yeah.

8                   Q.         And what does that indicate to you?

9                   A.         That indicates patient complains of  
10                  dyspareunia since posterior colporrhaphy and severe  
11                  menopausal symptoms.

12                  Q.         So two years after her TVT procedure,  
13                  she was relating her dyspareunia to her posterior  
14                  procedure; is that correct?

15                  A.         In the July 11th note, that is correct.

16                  Q.         Did Dr. Hill examine her at that time,  
17                  according to your review of the deposition and your  
18                  review of the medical records?

19                  A.         Yes.

20                  Q.         Did he palpate the site of his posterior  
21                  procedure?

22                  A.         Yes.

23                  Q.         And is that where she claimed  
24                  discomfort?

1 A. I don't quite recall.

2 Q. Did you read Chad Hill's deposition?

3 A. I did.

4 Q. And did Chad Hill indicate that there  
5 was no pain upon insertion at that time?

6 A. As I recall, that's what was stated in  
7 the deposition.

8 Q. And the area that he found tenderness  
9 was where the rectocele repair was done, that being the  
10 second procedure that he did, correct?

11 A. Well, that's somewhat in conflict to  
12 your original question. Could we repeat the second to  
13 last question, just so I understand it.

14 Q. Okay. Dr. Hill palpated the area where  
15 he had done the second procedure, correct?

16 A. Yes.

17 Q. And that's where she claimed that there  
18 was tenderness, correct?

19 A. In the July 11th visit, yes.

20 Q. Okay. Now, where is her pain now?

21 A. As of my most recent evaluation of her,  
22 her pain is in the anterior vaginal wall.

23 Q. Is that different than what she was  
24 complaining to Dr. Hill about?

1 A. Only on July 11th, this is true, yes.

2 Q. In any of Dr. Hill's records or during  
3 his deposition, was there ever complaints in the  
4 anterior compartment?

5 A. Yes, sir.

6 Q. And when was that?

7 A. September 29th, 2011.

8 Q. And in his report did he indicate she  
9 had pain in the anterior compartment at that time?

10 A. As I recall the medical record  
11 documents, complaints of severe anterior vaginal  
12 dyspareunia that had been present since her TVT-O and  
13 posterior colporrhaphy surgery.

14 Q. And did he examine her at that time?

15 A. I don't recall. If there was an  
16 examination, I don't -- obviously didn't include it in  
17 my report, so I don't know if it was necessarily  
18 contributory to her complaint.

19 Q. Where did you locate the pain?

20 A. When I examined her, she did have pain  
21 in the anterior vaginal wall.

22 Q. Where on the anterior vaginal wall?

23 A. Show you here. Just going to find my  
24 examination documentation in my report. It was

1       reproducible on the left vaginal sulcus in the area  
2       where her sling was excised and partially removed.

3       That's under Opinion 5.

4           Q.       And I'm looking at your actual notes  
5       from your examination.

6                   So it's the left vaginal sulcus, and  
7       when you say that, do you mean below the urethra or  
8       toward the bottom of the vaginal vault?

9           A.       If you can imagine the vaginal space, it  
10      would be probably along the location of the mid urethra  
11      in the typical location of where a transobturator sling  
12      is seated underneath the urethra.

13          Q.       So are you -- if we use the face of a  
14      clock, are you talking about 12:00?

15          A.       I'm talking about probably 1:30 to 2:00,  
16      yes, sir.

17          Q.       Okay. And how far in?

18          A.       Probably in the expected location if you  
19      were to draw an imaginary line from the mid urethra  
20      towards the obturator canal, probably right along that  
21      trajectory.

22          Q.       Now, where did the patient describe pain  
23      to Dr. Miklos?

24          A.       The vaginal opening.

1 Q. Was that a different location than where  
2 you had found it?

3 A. Not necessarily. If I may, he  
4 documented that she had no vulvar pain, that the pain  
5 was at the vaginal opening and with intercourse at  
6 entry.

7 And if you imagine the location of the  
8 urethral opening, which can be variable in certain  
9 patients, but in Ms. Martin's instance is essentially  
10 at the level of the vaginal introitus, 1 centimeter is  
11 not very far in, if you will.

12 Q. Okay. Your examination found pain  
13 suburethral, correct?

14 A. Part of her location of her pain was  
15 suburethral, that's correct.

16 Q. And he found pain where exactly?

17 A. He described pain at entry and pain at  
18 the vaginal opening.

19 Q. Did he actually look for pain  
20 suburethral?

21 A. Well, I imagine it may be semantics, but  
22 suburethral and vaginal opening in a sense can be  
23 synonymous, simply because if one is putting one's  
24 examining finger into the vaginal space, you're

1 immediately suburethral upon entry, particularly if  
2 you're palpating anteriorly on the upper part of the  
3 vaginal space.

4 Q. And you're saying "upper," you're saying  
5 on the -- you said 1:30 position is where you palpated  
6 and found tenderness?

7 A. That was where the vaginal sulcus on the  
8 left side is, yeah.

9 Q. So that would be periurethral bilateral,  
10 but one-sided?

11 A. One side greater than the other.

12 Q. Okay. So you would be looking for pain  
13 periurethral on the left side to match what you found,  
14 correct?

15 A. That's where the most sensitive area was  
16 on examination.

17 Q. Did you examine her -- the ring where  
18 her hymen would have been?

19 A. Yes, sir.

20 Q. And what did you find there, any pain  
21 there?

22 A. As I recall, there was -- and I'd have  
23 to look at my IME to get the verbiage correct, but the  
24 pain wasn't just in one particular area.

1 MR. GRIFFIN: Why don't we mark this  
2 Exhibit 2.

3 (Document marked for identification as  
4 Walmsley-Martin Deposition Exhibit No. 2.)

5 BY MR. GRIFFIN:

6 Q. I'm going to show you what's Exhibit 2.  
7 Is that the notes from your evaluation  
8 of Ms. Martin?

9 A. Yes, sir. Thank you.

10 Q. From that can you read to us where you  
11 identified the pain?

12 A. Yes. "On vaginal exam she had  
13 tenderness especially along the left vaginal sulcus  
14 were palpable scars appreciated."

15 Q. And that left vaginal sulcus would be  
16 suburethral or periurethral, correct?

17 A. That's correct, perhaps more  
18 periurethral in terms of the vaginal sulcus.

19 Q. Right. Did Dr. Miklos test that area?

20 A. I imagine he did, yes.

21 Q. Do you know what he found?

22 A. I'd have to look at the records to  
23 specifically tell, but my report states that he did  
24 suggest scar revision surgery and a laparoscopic Burch

1 procedure for her incontinence.

2 Q. What kind of scar revision surgery was  
3 he going to do?

4 A. He had intended on performing a vaginal  
5 and vulvar scar revision along with a perineoplasty,  
6 which describes work on the posterior vaginal space in  
7 anticipation of her moving additional scar material.

8 Q. Well, he recommended two things, did he  
9 not, a laparoscopic Burch and a perineoplasty?

10 A. That's correct, well actually three  
11 things, if you include the scar revision surgery.

12 Q. Where was the scar that he wanted to  
13 take care of, was it suburethral?

14 A. He described it as vaginal and vulvar,  
15 so, I mean, vaginal can certainly include the  
16 suburethral and/or periurethral area for that matter.

17 Q. Was it at the opening, or was it at the  
18 suburethral in the anterior compartment?

19 A. Well, I mean, I think, once again, those  
20 two terms are synonymous in terms of I guess my  
21 description or our description.

22 Q. Okay. Just so we're clear, he  
23 recommended two procedures, correct?

24 A. I would say three.

1 Q. Okay. I'm going to show you his medical  
2 record. This is MDR 30. These are Martin -- Patricia  
3 Martin's record, and this would be International Center  
4 for Laparoscopic Urogynecology.

5 A. Yes, sir.

6 Q. Do you remember reviewing the pictures?

7 A. Yes.

8 Q. Okay. And the first thing is  
9 incontinence, the diagnosis, and what does he recommend  
10 for that?

11 A. A laparoscopic Burch.

12 Q. And the second thing is a vaginal  
13 opening scar, that's the diagnosis. What does he  
14 recommend for that?

15 A. Perineoplasty.

16 Q. And that would be in the posterior  
17 compartment, correct?

18 A. Perineoplasty is in the posterior  
19 compartment, that's correct.

20 Q. That would not be the area where the  
21 mesh was, correct?

22 A. If that's what he was to do, yes.

23 Q. And that's what he, in fact, gave her on  
24 the recommendation sheet that's attached to his file,

1 isn't it, you reviewed that?

2 A. He suggested that, yes.

3 Q. Now, Dr. Miklos in his records did not  
4 suggest her dyspareunia was caused by the sling or by  
5 contraction of mesh, did he?

6 A. May I?

7 Q. Sure.

8 A. (Witness reviews records.)

9 May I hear the question back.

10 (The court reporter read back the record  
11 as requested.)

12 THE WITNESS: There's no comment in his  
13 medical records attributing dyspareunia to  
14 mesh.

15 BY MR. GRIFFIN:

16 Q. He also did not suggest removal of any  
17 mesh, did he?

18 A. With her having had mesh removal by  
19 Dr. Marinis, if I'm saying his name correctly, he did  
20 not.

21 Q. In fact, Dr. Miklos found no pain  
22 suburethral or periurethral, did he?

23 A. His examination note didn't indicate  
24 that.

1 Q. That's the area where you found pain,  
2 though, correct?

3 A. I found pain at -- and you and I have  
4 used these terms synonymously, the entry area and  
5 specifically on my exam in the anterior vaginal wall in  
6 the area of both sub and perivaginally, but, once  
7 again, suburethra and vaginal opening are synonymous.

8 Q. Well, Dr. Miklos found absolutely no  
9 pain suburethral or periurethral in his examination,  
10 true?

11 MR. THOMPSON: Object to the form.

12 THE WITNESS: His part of his medical  
13 record states that, yes.

14 BY MR. GRIFFIN:

15 Q. Okay. And suburethral and periurethral  
16 would be where the mesh was, correct?

17 A. Well, suburethral where the mesh was,  
18 periurethral where the mesh still is and was, because  
19 not all of the mesh was removed.

20 Q. Okay. But that -- whatever mesh would  
21 be suburethral or periurethral, correct?

22 A. Depending upon semantics, that's  
23 correct.

24 Q. Well, Dr. Miklos specifically found zero

1 out of five pain suburethral and periurethral, correct?

2 A. In part of his exam he documents that.

3 Q. And looking at your opinions in this

4 matter, your Opinion Number 1, I think goes primarily

5 to the IFU; does it not?

6 A. Yes, sir.

7 Q. And is it my understanding that if the  
8 IFU had included mesh contraction, mesh shrinkage, scar  
9 plate formation and dyspareunia, then the IFU would  
10 have been sufficient, in your mind?

11 MR. THOMPSON: Object to the form.

12 THE WITNESS: In part, yes.

13 BY MR. GRIFFIN:

14 Q. The second part of that goes to what  
15 Dr. Hill did or didn't know, what he had knowledge of,  
16 as I understand your Opinion Number 1; is that correct?

17 A. Yeah, based on the insufficiency of the  
18 IFU, yes.

19 Q. Okay. Did Dr. Hill read the IFU?

20 A. Not to my knowledge.

21 Q. So whatever was in the IFU, he would not  
22 have obtained from reading it, correct?

23 MR. THOMPSON: Object to the form.

24 THE WITNESS: Unless he had been briefed

1                   on the IFU by someone with the company when  
2                   training on this.

3     BY MR. GRIFFIN:

4                   Q.        And what knowledge did Dr. Hill have of  
5     the potential risk and complications of the TVT-O?

6                   A.        Well, based on the medical record, he  
7     did run through a couple of things.

8                   Q.        Did you review his deposition?

9                   A.        I did.

10                  Q.        In his deposition did he indicate that  
11     he was aware of the risk of mesh contraction, mesh  
12     shrinkage, dyspareunia, pelvic pain?

13                  A.        To some degree he stated that.

14                  Q.        Did he testify that he was aware of all  
15     of those things from his training, from discussions  
16     with colleagues and from reading the literature?

17                  A.        He made comments to that effect.

18                  Q.        Did he indicate that even if you had  
19     included all of these other complications in the IFU,  
20     it would not have changed his recommendation to use the  
21     TVT in this case?

22                  A.        I can't really lend any credence to that  
23     comment.

24                  Q.        Well, did you read his deposition where

1 he said that?

2 A. I did.

3 Q. Did Dr. Hill indicate that the IFU did  
4 not have anything to do with his recommendation or to  
5 use a TVT-O?

6 A. I don't recall the language used, but I  
7 do acknowledge that he didn't read the IFU.

8 Q. Did he -- whether or not all of the  
9 information you contend should be in the IFU, you do  
10 admit that Dr. Hill was aware of those risks according  
11 to his testimony?

12 MR. THOMPSON: Object to the form.

13 THE WITNESS: Well, I would argue no.

14 BY MR. GRIFFIN:

15 Q. Did he testify he was aware of them?

16 A. Based on his training and discussions  
17 with colleagues, he made comments to that effect.

18 Q. Okay. Well, a physician obtains  
19 information regarding the risks and complications of  
20 any particular procedure from a number of sources,  
21 don't they?

22 A. I think that's a fair comment.

23 Q. I mean, one of the sources is the IFU,  
24 correct?

1 A. Yes, sir.

2 Q. Another source would be the training  
3 that they get in a particular procedure, whether it's  
4 in their residency or after their residency and  
5 seminars, things of that sort?

6 A. I think that's a fair comment.

7 Q. It's also based upon their own  
8 experience; different physicians have different  
9 experiences, true?

10 A. I agree.

11 Q. And it's also based upon the literature  
12 that they might read or come in contact with, true?

13 A. I concur.

14 Q. And all of that information goes in to  
15 the physician's makeup, in essence, in order to give  
16 adequate informed consent to a patient, true?

17 A. I think that's true, but that depends  
18 upon, for example, if one's discussions with other  
19 colleagues, if one's training, if one's review of the  
20 literature has been influenced by an appropriate IFU.

21 Q. Well, did Dr. Hill agree that he was  
22 aware of all of the potential risks and complications  
23 which you indicate should be in the IFU based upon his  
24 training, experience and his discussions with

1       colleagues?

2           A.       To the best of his knowledge.

3           Q.       Your Opinion Number 2 is that, as I  
4 understand it, safer alternatives existed in 2009?

5           A.       Yes, sir.

6           Q.       But as of 2009 you were doing TTV-type  
7 procedures yourself, correct?

8           A.       I was.

9           Q.       And you were trying to provide the best  
10 care for your patients, true?

11          A.       Yes, sir.

12          Q.       And, as I understand it, you do not  
13 intend to give opinions as a design expert; is that  
14 correct?

15          A.       No, I'm not planning on doing that.

16          Q.       You indicate because of lack of  
17 information in the IFU, Dr. Hill could not warn  
18 Ms. Martin of the complications?

19          A.       That's correct.

20          Q.       At the time you wrote that in your  
21 report, you had not had an opportunity to review  
22 Dr. Hill's deposition; is that correct?

23          A.       That's correct.

24          Q.       Since you reviewed Dr. Hill's

1 deposition, do you agree that he did have the  
2 information available to warn Ms. Martin of  
3 complications?

4 A. I do not.

5 Q. And why do you say you do not, when he  
6 says he did have that information?

7 MR. THOMPSON: Object to the form.

8 THE WITNESS: Because my opinion is that  
9 the IFU, whether it's read by an implanting  
10 surgeon or not, is one of the important  
11 foundations to provide informed consent, and  
12 when anyone, myself or anyone else, decides to  
13 perform a procedure using a device, I  
14 personally rely upon the IFU, but in the  
15 absence of reading the IFU, I'm deriving  
16 information from key opinion leaders, my own  
17 experience, literature, and all that  
18 literature, to some degree, is founded on a  
19 thorough IFU.

20 For example, if Dr. Hill had asked one  
21 of his colleagues down the street, hey, you  
22 know, I want to implant this TVT-O, what do you  
23 know about it, and if the other implanting  
24 surgeon had actually read the IFU he might say,

1 well, you know, it definitely is easier than an  
2 autologous fascial sling; however, you know,  
3 there are some real potential risks to the  
4 mesh, and sometimes when these patients have  
5 dyspareunia, it's very difficult to treat.

6           Might that have influenced or improved his fund  
7           of knowledge going into surgery? I believe it  
8           would.

9 BY MR. GRIFFIN:

10 Q. Did any of that occur or not occur, or  
11 do you know?

12                   A.         Well, based on his deposition and what  
13         you and I have discussed, it would seem that his fund  
14         of knowledge, which he claims is complete, I would  
15         argue is tainted by the fact that the IFU at that time  
16         was incomplete.

17 Q. Did he testify he was aware of the risk  
18 of acute and/or chronic pain with intercourse?

19 MR. THOMPSON: Object to the form.

20 THE WITNESS: As I recall, he did make  
21 that statement.

22 BY MR. GRIFFIN:

23 Q. Did he testify that he was aware that  
24 there was a risk of acute and/or chronic pain?

1 MR. THOMPSON: Object to the form.

2 BY MR. GRIFFIN:

3 Q. With the use of mesh or indeed with  
4 nonmesh procedures?

5 A. He did, although I don't recall the date  
6 of the deposition, but it was fairly recent, if my  
7 memory serves me.

8 Q. And did he indicate he was aware of all  
9 of these things before he ever performed a procedure on  
10 Ms. Martin?

11 A. As I recall, that comment was made.

12 Q. And he also testified that he was aware  
13 of the risk of infection, urinary problems, organ nerve  
14 damage, bleeding, wound complications, inflammation,  
15 fistula formation, neuromuscular problems, one or more  
16 revision surgeries to treat an adverse event,  
17 recurrence, failure, foreign body response, erosion,  
18 exposure, extrusion and contraction or shrinkage of  
19 tissues?

20 A. Sounds like you read part of the IFU,  
21 sorry, but he did make that comment, yes.

22 Q. He did agree that he knew all those  
23 risks and complications, correct?

24 A. He commented on that at his deposition,

1 yes.

2 Q. And he testified that he was aware of  
3 all that information before he made the implantation of  
4 the TVT-O device in Ms. Martin, correct?

5 MR. THOMPSON: Object to the form.

6 THE WITNESS: He made comments to that  
7 effect in his deposition, yes.

8 BY MR. GRIFFIN:

9 Q. In Opinion Number 3 you indicate that  
10 Ms. Martin suffered a vaginal sling contraction and  
11 scar plate formation as a result of the physical  
12 properties of the TVT device, true?

13 A. Yes, sir.

14 Q. And it's your opinion that the TVT  
15 contracted post implantation?

16 A. That's correct.

17 Q. And what do you base that on?

18 A. I base that on Dr. Marinis' operative  
19 dictation, the findings of the tape being tense or taut  
20 upon removal. I also base that on changes to the  
21 bladder which were seen at the time of sling removal.

22 Q. And I'm going to butcher this word,  
23 trabeculations?

24 A. Trabeculations being that finding, yes,

1 sir.

2 Q. And you indicated that this caused  
3 trabeculations that were not present on prior -- they  
4 were not present on prior cystoscopies, correct?

5 A. Yes, sir.

6 Q. Were they present on subsequent  
7 cystoscopies as well, the trabeculations?

8 A. I don't recall that terminology being  
9 used.

10 Q. Once they're there, they're going to  
11 stay there, though, right?

12 A. They tend to persist even beyond the  
13 removal of the offending cause, if you will.

14 Q. So subsequent cystoscopies should turn  
15 that up if we look for them, correct?

16 A. Theoretically, they should show some  
17 degree of trabeculations, yes, sir.

18 Q. Right. And the other reason you  
19 indicated that it appeared that the mesh was -- the  
20 mesh had contracted was because her inability to void  
21 completely, I guess would be the proper word, started  
22 at some point subsequent to the surgery, it was  
23 gradual?

24 A. That symptom development, yes, started

1 gradually after that surgery.

2 Q. Did she, in fact, have that symptom  
3 before she ever had the surgery?

4 A. When you say that surgery, you're  
5 referring to the TVT-O surgery?

6 Q. Yes.

7 A. I have to see the historical records to  
8 confirm that.

9 Q. Well, you read her deposition, didn't  
10 you?

11 A. I did.

12 Q. And in her deposition did she not  
13 indicate that she had problems emptying her bladder  
14 before she ever had a TVT-O procedure?

15 A. I recall seeing that, although I don't  
16 see anything in the medical records that speak to that.

17 Q. But we do have her sworn testimony that  
18 she had problems emptying her bladder. When she would  
19 go to the restroom, she would feel like there was still  
20 urine left that she couldn't empty, true?

21 A. Yes.

22 Q. So one of the basis for your opinion  
23 that it contracted was the fact that she had developed  
24 this inability to empty her bladder completely,

1 correct?

2 A. To some degree, yeah.

3 Q. And, in fact, she had those symptoms,  
4 according to her testimony, before she ever had the  
5 TVT-O procedure true?

6 A. I'm not sure to the same severity with  
7 which she developed them following, but her deposition  
8 would say that, would indicate that.

9 Q. To be fair, you weren't there to assess  
10 her before or after, correct?

11 A. This is true.

12 Q. All we have is her testimony as to when  
13 this problem began, correct?

14 A. Yes.

15 Q. And this problem with emptying her  
16 bladder began before the TVT procedure was ever  
17 performed, according to her testimony, correct?

18 MR. THOMPSON: Object to the form.

19 THE WITNESS: In her deposition she made  
20 comments to that effect, yes.

21 BY MR. GRIFFIN:

22 Q. And your next opinion is Opinion 4. And  
23 do I understand Opinion 4 correctly that you have  
24 outlined the causes of dyspareunia and ruled in or

1       ruled out certain potential causes?

2           A.       Yes.

3           Q.       So you ruled out vestibulitis because it  
4       was not documented in the medical record anywhere,  
5       correct?

6           A.       There's a question of vestibulitis, I  
7       believe, in Dr. Marinis' records that are more or less  
8       ruled out, as I recall.

9           Q.       Okay. So as I understand it, you ruled  
10      out vestibulitis as a potential causes for dyspareunia  
11      because it was not documented in the medical records,  
12      correct?

13          A.       Not precisely.

14          Q.       Okay.

15          A.       There was a question raised as to  
16      vestibulitis in the records of Dr. Marinis; however,  
17      the treatment that would have otherwise resolved that  
18      condition were completely ineffective.

19          Q.       Well, is your point vestibulitis was  
20      never definitively diagnosed by anybody in the medical  
21      records, and that's why you ruled it out?

22          A.       That's correct.

23          Q.       And if it is documented by the treating  
24      physicians, you wouldn't rule it out, correct?

1                   A.         If it was documented and found to be  
2         true, based on subsequent records and evaluation, I  
3         would not.

4                   Q.         You would not rule it out, true?

5                   A.         That's correct.

6                   Q.         Okay. Did you rule out pain in the area  
7         of the colporrhaphy?

8                   A.         I did.

9                   Q.         And that's because it's not documented  
10        in the records, correct?

11                  A.         No, that's because my independent  
12        medical exam indicated no pain to palpation in the area  
13        of the posterior colporrhaphy, nor did her subjective  
14        pain exist in that area.

15                  Q.         You ruled out vaginal tissue atrophy  
16        because it was not mentioned in the records, correct?

17                  A.         That's not precisely true either.

18                  Q.         You found it, I understand that, in 2016  
19        but --

20                  A.         That was the point I wanted to make.

21                  Q.         Okay. But your point is in the 2011,  
22        '12 period, there was no mention of vaginal tissue  
23        atrophy, correct?

24                  A.         That was part of -- yeah, part of my

1 conclusion was based on that finding, yes.

2 Q. And so one way to determine whether the  
3 patient has vaginal tissue atrophy and that's causing  
4 dyspareunia is to use the hormonal creams, correct?

5 A. That's one of the treatments of vaginal  
6 tissue atrophy.

7 Q. And if the patient notes improvement  
8 upon using the cream, that gives you some indication  
9 that her dyspareunia may be caused by the lack of  
10 estrogenization or the vaginal tissue atrophy, correct?

11 A. Can be a contributing factor.

12 Q. And the reason you ruled that out was  
13 because that was not documented in the medical records  
14 either, true?

15 A. Part of the reason, yes.

16 Q. Any other reason you ruled it out?

17 A. Yes, sir.

18 Q. What?

19 A. Well, specifically for a good period of  
20 time, she was on oral hormonal replacement therapy,  
21 number one. And subsequent to the discontinuation of  
22 the Cenestin, which is C-e-n-e-s-t-i-n, she was more or  
23 less on topical hormonal therapy throughout her  
24 treatments.

1 Q. Did she ever note improvement with the  
2 topical hormone?

3 A. As I recall, she may have, but I don't  
4 specifically recall there.

5 Q. You don't recall one way or the other?

6 A. Only insofar as in formulating this  
7 opinion based on -- certainly, based on the medical  
8 record review and my independent medical examination,  
9 whereas vulva vaginal atrophy essentially creates a  
10 somewhat diffuse dyspareunia, her dyspareunia was  
11 fairly site specific.

12 Q. Well, hers was to the point. She said  
13 her husband could not enter her, correct?

14 A. At times, yes.

15 Q. Did you rule out that the patient may  
16 need a vestibulectomy?

17 A. I did rule that out.

18 Q. And is that because it was not stated in  
19 the medical records?

20 A. In part, yes.

21 Q. And the other thing you excluded was  
22 pelvic floor dysfunction because of absence of  
23 tenderness to the pelvic floor musculature, correct?

24 A. During my examination, yes, and that of

1 Dr. Miklos as well.

2 Q. And you ruled out pudendal neuropathy,  
3 true?

4 A. I did, yes.

5 Q. And how did you rule that out?

6 A. Based on several factors, one being, of  
7 course, my independent medical examination, both  
8 clinically and examination-wise, and then on the basis  
9 of the lack of documentation on Dr. Miklos' part and,  
10 thirdly, more or less on the basis of Dr. Marinis  
11 entertaining this concept yet seeing no resolution with  
12 the typical treatments used to treat pudendal  
13 neuropathy.

14 Q. So if we wanted to rule back in  
15 vestibulitis, we would have to find that in the medical  
16 records, that some physician had diagnosed that,  
17 correct?

18 A. I think to some degree it depends on the  
19 chronology and timing of that diagnosis, number one,  
20 and, number two, whether or not the traditional  
21 therapies for that have led to relief of symptoms.

22 Q. Well, one of the therapies, of course,  
23 is going to be a vestibulectomy, correct?

24 A. For vestibulitis you mean?

1 Q. Yes, yes.

2 A. Yes.

3 Q. I'm going to show you the records from  
4 Premier Care for Women. This is dated 4/19/2012, and  
5 there was an examination done by Dr. Peacock at that  
6 time, and this is Premier Care for Women, MDR 16.

7 What does she diagnose at that time  
8 regarding vestibulitis?

9 Did you find that, Doctor?

10 A. There's a comment in there regarding  
11 vestibulitis present.

12 Q. And this physician on April 19, 2012  
13 diagnosed vestibulitis in this particular patient,  
14 Ms. Martin, correct?

15 A. Yes.

16 Q. And, in fact, Dr. Peacock discussed with  
17 the patient a vestibulectomy, correct?

18 A. In part.

19 Q. Dr. Peacock also discussed with the  
20 patient that her dyspareunia may have been the  
21 vestibulodynia and unrelated to the sling, true?

22 A. As part of her discussion, she mentions  
23 that.

24 Q. She also discussed the area in the upper

1 posterior vagina that may require physical therapy,  
2 correct?

3 A. Can you repeat the question again. I'm  
4 sorry.

5 Q. She also discussed with the patient that  
6 the upper posterior area of the vagina may require  
7 physical therapy, massage therapy to relieve, true?

8 A. That's what's stated there, yes.

9 Q. And that area would not be where the  
10 mesh is, true?

11 A. That area is not where mesh is located.

12 Q. And the vestibulitis, that is not caused  
13 by mesh, true?

14 A. Possibly. It's unclear to me.

15 Q. There's no study that suggests that,  
16 correct?

17 A. Well, there's also no study that I know  
18 of that correlates pudendal neuropathy to mesh, and  
19 Dr. Marinis makes that claim in his assessment too.

20 Q. But there's no study that you've read  
21 that links vestibulitis with mesh, correct?

22 A. Not that I'm aware of.

23 Q. Okay. So you have no scientific  
24 evidence that would suggest that vestibulitis is caused

1 by the implantation of mesh, correct?

2 MR. THOMPSON: Object to form.

3 THE WITNESS: Not directly.

4 BY MR. GRIFFIN:

5 Q. So potentially we can rule the  
6 vestibulitis back into the picture, correct, for a  
7 potential cause of the dyspareunia, correct?

8 A. Perhaps in 2012, that would be in the  
9 differential.

10 Q. One of the other -- we talked about  
11 vaginal tissue atrophy. That is one of the things that  
12 Dr. Peacock found in April of 2012, correct?

13 A. I'm sorry. Where do you see that?

14 Q. Maybe I can help you, Page 19.

15 A. I don't have Page 19 here. I'm sorry.

16 Q. It's probably not in order. It's after  
17 this picture.

18 A. Oh, I see that now.

19 Q. There's a history and physical.

20 A. Yes, yes, you're talking about from  
21 May 17th, 2012, correct?

22 Q. Right.

23 A. That's interesting.

24 Q. And on that history and physical, what

1       happened when the patient started using Estrace and  
2       Vagifem?

3           A.       Discussed modest improvements, that's  
4       what's stated in the plan.

5           Q.       Okay. Under the history of present  
6       illness on Page 19, do you have that, Page 19?

7           A.       I see that, yes.

8           Q.       5/17/12, has been using Estrace and  
9       Vagifem, still with some dyspareunia but husband can  
10      now enter her.

11          A.       I see that.

12          Q.       Do you see that?

13           And Estrace and Vagifem would be  
14      estrogen creams, correct?

15          A.       That's correct.

16          Q.       And then if you go to Page 20 under the  
17      examination of the external genitalia.

18          A.       Yes.

19          Q.       It indicates vestibulitis present and  
20      the atrophy was improving.

21          A.       I see that.

22          Q.       That would indicate that some of her  
23      dyspareunia at least may well have been caused by the  
24      fact she was not adequately estrogenized or she had

1 vaginal atrophy, correct?

2 MR. THOMPSON: Object to the form.

3 THE WITNESS: In 2012 I would concur.

4 BY MR. GRIFFIN:

5 Q. And she, in fact, had vaginal tissue  
6 atrophy when you examined her in 2016, correct?

7 A. I described it as mild as I recall, but,  
8 yes, nontender to vulvar palpation, as I documented.

9 Q. So vaginal tissue atrophy is something  
10 we can rule back in now that we've looked at the  
11 medical records, correct, as a cause of dyspareunia,  
12 true?

13 A. I would disagree with that.

14 Q. Well, at least as of 2012, we can rule  
15 it back in, correct?

16 A. I think based on Dr. Peacock's  
17 assessment, there's truth to that, yes.

18 Q. So as of 2012 when Dr. Peacock was  
19 examining the patient, we can rule back in vaginal  
20 tissue atrophy as a potential cause of her dyspareunia?

21 A. I wouldn't necessarily agree with that,  
22 although it's stated in that page, and I can tell you  
23 why, if you'd like.

24 Q. Well, it is stated by the physician at

1 that time, true?

2 A. This is true.

3 Q. And, apparently, prior to the use of the  
4 creams, the patient could not have her husband enter  
5 her, correct?

6 A. It would appear that way.

7 Q. And Dr. Peacock noted that the vaginal  
8 tissue was improving once the patient had been on the  
9 cream for about a month, true?

10 A. Well, I think her records conflict with  
11 that finding, quite frankly.

12 Q. What conflicts with her records?

13 A. Well, her initial assessment on  
14 April 19th, there's no documentation whatsoever of any  
15 vulvar atrophy, so I don't understand her basis for  
16 saying vulvovaginal atrophy is improving when it wasn't  
17 even there in April.

18 Q. So why would she give her a prescription  
19 of Estrace and Vagifem?

20 A. I think it's not appropriate to do so  
21 for someone who has dyspareunia and who is not  
22 producing estrogen. I do that all the time, quite  
23 frankly. I just don't understand why she would make a  
24 comment to the effect of vulvovaginal atrophy is

1 improving where a month ago, based on her  
2 documentation, there was no vulvovaginal atrophy.  
3 That's my concern.

4 Q. But, in any event, her May 2012 report  
5 would indicate that her vaginal tissue atrophy was  
6 improving with the use of the estrogen creams and her  
7 dyspareunia improved as well, correct?

8 A. She made that comment, yeah.

9 Q. Had this patient had problems with  
10 dyspareunia in the past before she ever had a TVT-O?

11 A. She did.

12 Q. And what was that related to?

13 A. By her report and based on my  
14 discussions with her at the time of my IME, it was  
15 based on an episiotomy scar.

16 Q. And the episiotomy scar had to be  
17 revised?

18 A. The scar tissue was removed in 2003, in  
19 fact.

20 Q. Did she have a scar from the revision  
21 itself?

22 A. Based on my review of the medical  
23 records, it appears she doesn't have much scar tissue  
24 related to that.

1 Q. And you excluded pelvic floor  
2 dysfunction, true?

3 A. Yes, sir.

4 Q. Did any of the other physicians note  
5 pelvic floor dysfunction?

6 A. Yes.

7 Q. Who did?

8 A. Dr. Marinis entertained that diagnosis  
9 during his evaluation.

10 Q. And did he find it?

11 A. Well, he specifically, and I quote,  
12 entertained the diagnosis of pudendal neuropathy caused  
13 indirectly by the TVT-O mesh, and based on that,  
14 entertained that diagnosis and actually attempted  
15 treatment of such with medication.

16 Q. And your examination ruled that out as  
17 well, correct?

18 A. Yes, it did.

19 Q. Okay. So of the things you mentioned,  
20 vestibulitis now appears in the medical records, which  
21 you had overlooked earlier, correct?

22 A. I didn't see that.

23 Q. Okay. And the pain in the area of the  
24 colporrhaphy, that was in the medical records from

1 Dr. Chad Hill, correct?

2 A. That's correct.

3 Q. And does Dr. Peacock also address pain  
4 in the posterior of the vagina? She intends to do some  
5 type of physical therapy, correct?

6 A. It's suggested -- well, there were a  
7 couple of issues in the posterior wall that she  
8 discusses, one being the rectocele and the other being  
9 pain in the upper posterior area of the vaginal space.

10 Q. Neither one of those things would be  
11 related to mesh, true?

12 A. This is true.

13 Q. And like Dr. Miklos, Dr. Peacock also  
14 did not suggest that mesh was causing any of this  
15 patient's problems, correct?

16 A. There's no mention either of that in her  
17 notes.

18 Q. So we have two urogynecologists looking  
19 at this patient a few short months after the surgery by  
20 Dr. Marinis, correct?

21 A. Several months after she saw Dr. Miklos,  
22 and soon thereafter she saw Dr. Peacock.

23 Q. Neither one of these physicians  
24 mentioned the -- do you have your examination notes I

1 think we marked as an exhibit?

2 A. Yes, sir.

3 Q. Neither one of the physicians who saw  
4 this patient shortly after Marinis' deposition -- or  
5 surgery, I'm sorry -- indicated that this -- that they  
6 felt tenderness along the left vaginal sulcus where a  
7 palpable scar is appreciated, true?

8 A. I don't see that present in their  
9 records.

10 Q. And both conducted pelvic examinations  
11 on this patient, true?

12 A. They did.

13 Q. Then we go to Opinion Number -- one of  
14 the reasons for stating -- let me before we get to  
15 Opinion 5, one of the other reasons you stated that you  
16 felt there was a contraction is because she slowly had  
17 this inability to void, this slower urine flow and that  
18 this came on gradually after the TVT procedure, true?

19 A. It can occur gradually, this is true.

20 Q. Isn't one of the basis for your opinion  
21 that there was a contraction of the mesh is that the --  
22 that there was this gradual development of slower flow  
23 and inability of her to empty her bladder?

24 A. Well, I think the healing process after

1 these procedures is such that although the development  
2 over a long period of time might seemingly be gradual,  
3 in a lot of instances, patients immediately following  
4 surgery can actually have voiding dysfunction primarily  
5 related to inflammation and swelling at the immediate  
6 time of surgery.

7 Q. It can also be related by over  
8 tensioning of the device, correct?

9 A. That can sometimes occur.

10 Q. Can you over tension one side but not  
11 the other?

12 A. It's somewhat difficult to do that,  
13 functionally and mechanically speaking.

14 Q. It doesn't really make sense, does it?

15 A. The point you just made you mean?

16 Q. It doesn't really make sense that you  
17 could have more tension on one side than the other in a  
18 TVT-O device?

19 A. Unless there's difficulty removing the  
20 sleeves around the mesh, it's very hard to imagine that  
21 happening.

22 Q. And there was -- have you ever been able  
23 to pull on a TVT-O while it's still implanted without  
24 opening up the patient?

1                   A.         I'm not sure if I understand that  
2 question.

3                   Q.         Well, you know, Dr. Marinis indicated he  
4 pulled on the TVT, and, in fact, the patient mentioned  
5 that as well, true?

6                   A.         I guess I'm trying to understand the  
7 context in which you're referring to that. You're  
8 talking outside of the operating room?

9                   Q.         Yeah, examination.

10                  A.         Oh, yes, he did, when he examined her --  
11 I'm not convinced he actually pulled it, but he  
12 palpated it was my interpretation of that exam.

13                  Q.         She, in fact, told the told Dr. Peacock  
14 that it was never tender on exam when the sling itself  
15 was palpated only when pulling on it?

16                  A.         I'm not sure what to make of that. I  
17 don't understand that.

18                  Q.         Well, Doctor --

19                  A.         I saw that in her notes.

20                  Q.         It would hurt her if you pulled on it,  
21 wouldn't it?

22                  A.         How do you pull on it?

23                  Q.         That's what Dr. Marinis said he did,  
24 true?

1                   A.         I think Dr. Peacock made reference to  
2                   that.

3                   Q.         And didn't Dr. --

4                   A.         My interpretation of Dr. Marinis was  
5                   that he palpated it, and, in fact, I believe my report  
6                   speaks to that. Yes.

7                   Q.         Let me ask you about this pelvic pain on  
8                   the left vaginal sulcus. That's not posterior pain,  
9                   true?

10                  A.         No, sir.

11                  Q.         I guess that would be --

12                  A.         It's fascial sulcus is not posterior,  
13                  that's correct.

14                  Q.         Thank you for helping me out there.

15                              The area that you identified pain was  
16                  different than what Dr. Chad Hill identified, true?

17                  A.         No, not true.

18                  Q.         Okay. Chad Hill identified pain in  
19                  the -- where the colporrhaphy was done in his  
20                  examination, true?

21                  A.         Well, on September 29th, 2011 he states  
22                  otherwise.

23                  Q.         But he says that's what the patient  
24                  says, but, actually, on the examination three weeks

1 before that, he actually checked her, true?

2 A. He did examine her on July 11, 2011.

3 Q. And at that time he actually palpated  
4 the area where the colporrhaphy was done?

5 A. And, as I recall, he documented that it  
6 was a well healed colporrhaphy incision.

7 Q. And did he also testify that that was  
8 the area where she was feeling pain, where the  
9 colporrhaphy was done?

10 A. As I recall, yes.

11 Q. Okay. So that would be a different area  
12 than where you palpated and found tenderness, correct?

13 A. That's correct.

14 Q. And that's a different area, the area  
15 that you found pain was different than the area  
16 Dr. Peacock identified, true?

17 A. Well, it's unclear to me where  
18 Dr. Peacock felt pain, quite frankly, because her notes  
19 are conflicting.

20 Q. Well, certainly, the area that you felt  
21 pain would not lead one to a diagnosis of vestibulitis  
22 or the need for a vestibulectomy, correct?

23 A. This is true.

24 Q. And, likewise, the area you felt pain

1 would not lead one to the diagnosis or the need for a  
2 perineoplasty, correct?

3 A. To some extent, true.

4 Q. So both Dr. Miklos and Dr. Peacock were  
5 apparently identifying pain at a different spot than  
6 you were, correct?

7 A. Not necessarily.

8 Q. They certainly reached different  
9 diagnosis than you did, correct?

10 A. Well, they certainly reached different  
11 treatment plans, the both of them as well. I mean, one  
12 wants to do a perineoplasty, the other wants to do a  
13 vestibulectomy. One says there is no vulvovaginal  
14 atrophy, then she says the vulvovaginal atrophy is  
15 improving. So it's a little over the map, quite  
16 frankly.

17 Q. Would you agree with me that both the  
18 diagnosis and treatment plans of Dr. Miklos and  
19 Dr. Peacock are different than the diagnosis that you  
20 made?

21 A. I would conclude that all three are  
22 different.

23 Q. Okay. In Opinion Number 6 you say that  
24 she still has mesh in her body so she will continue to

1 experience dyspareunia?

2 A. That's correct.

3 Q. Where does she still have mesh?

4 A. When transobturator slings are  
5 implanted, there is a component of them that sits much  
6 like a hammock underneath the mid urethra and the  
7 vaginal space; however, there's also a component that  
8 exits the vaginal wall and extends through the  
9 obturator foramen and then comes out the groin crease  
10 bilaterally. When Dr. Marinis did his removal of the  
11 sling, he obviously left pieces in the left and right  
12 side in this patient.

13 Q. At the obturator?

14 A. I would argue near the obturator, and  
15 part of the reason I state that is because in a lot of  
16 instances when you examine these patients and you  
17 encounter an area of scar tissue, we call it induration  
18 sometimes, where the tissue is thickened, it's somewhat  
19 difficult to know if, in fact, that's purely fibrosis  
20 and scar tissue or whether or not there's any residual  
21 mesh there.

22 Q. There is no scar tissue -- there is no  
23 mesh in the area that you identified, currently there's  
24 no mesh in the area where you identified tenderness on

1 the vaginal sulcus, correct?

2 A. Well, that's not true exactly.

3 Q. Do you contend there is?

4 A. I would contend there most likely is,  
5 yes.

6 Q. Okay. And you say her dyspareunia would  
7 be ameliorated with further sling removal, correct?

8 A. Possibly, yes.

9 Q. And we can agree that that was not  
10 recommended by Dr. Miklos or Dr. Peacock, true?

11 A. True.

12 Q. How much were you paid to do the IME in  
13 this case?

14 A. I wasn't paid to do the IME, my group  
15 was paid.

16 Q. Okay. How much were they paid?

17 A. I believe \$350 or thereabouts.

18 Q. How many did you do that day, IMEs?

19 A. On that day, give you an exact answer,  
20 so give me one moment, please.

21 Yes, I did three that day.

22 Q. And that's Ms. Bailey, Ms. Martin and  
23 who else?

24 A. No, I did Mrs. Martin, Mrs. Manor and a

1 patient by the name of Macina.

2 Q. Did you do Bailey that day as well?

3 A. I did not.

4 Q. What is a relaxing perineoplasty?

5 A. Well, the easiest place to improve  
6 vaginal introital caliber is via a perineoplasty, and  
7 what that entails doing is removing, in this instance,  
8 either fibrotic -- possibly fibrotic and/or scar tissue  
9 in the hopes of expanding the vaginal opening, hence  
10 the concept of relaxing.

11 Q. Is there fibrotic tissue where the  
12 episiotomy was done and the episiotomy revision?

13 A. There's no documentation of that  
14 following her original episiotomy revision. That being  
15 said, she's had a posterior colporrhaphy since that  
16 time, so it's likely that there is.

17 Q. Okay. And that would have been the area  
18 that Dr. Miklos was operating in, true, wanted to  
19 operate in, correct?

20 A. One of the areas, yes.

21 Q. The other was to do the Burch procedure  
22 for the incontinence on his two recommendations,  
23 correct?

24 A. Partially correct, yes.

1 Q. And the area where he would do the  
2 perineoplasty was probably where the colporrhaphy scar  
3 is; is that what you're saying?

4 A. Not necessarily, no.

5 Q. Do you know where it is?

6 A. Well, the perineum is the very most  
7 distal element of the posterior wall, so posterior  
8 colporrhaphy extends from the perineum back towards the  
9 apex, if you will, of the vagina, the back part of the  
10 vagina.

11 Q. Right.

12 A. So it doesn't incorporate the entire  
13 area.

14 Q. Oh, so you're saying partially it  
15 includes that area?

16 A. It may. It depends on where the  
17 rectocele was located. If the rectocele was a more  
18 apical rectocele, you might not even get in touch with  
19 the perineum.

20 And, as I recall, based on Dr. Hill's  
21 operative note, I don't believe he does a  
22 perineoplasty, although I may be incorrect on that. I  
23 don't recall that being part of his surgery, although  
24 it typically is. At least in my practice it is.

1                   Q.         So that would be the area of scar  
2 revision, though, is that what we're talking about,  
3 when Dr. Miklos suggests the perineoplasty?

4                   A.         In part, yes.

5                   Q.         It's where the colporrhaphy scar is and  
6 the pre-existing perineoplasty was probably done,  
7 correct?

8                   A.         I can't draw that conclusion, it might  
9 be.

10                  Q.         Okay. I mean, that's the most logical  
11 thing, correct?

12                  A.         It might have nothing do with Dr. Hill's  
13 posterior repair, quite frankly.

14                  Q.         It doesn't have anything to do with the  
15 mesh either, true?

16                  A.         Once again, Dr. Miklos stated --  
17 counseled the patient towards vaginal and vulvar scar  
18 revision with perineoplasty and laparoscopic Burch.  
19 So, certainly, the perineoplasty would have nothing to  
20 do with the mesh.

21                  Q.         Okay. Tell me, what other procedures do  
22 you perform for stress urinary incontinence, other than  
23 the mesh procedures?

24                  A.         I perform suburethral collagen or

1 similar like injections. I also perform autologous  
2 fascial slings. I have had experience implanting  
3 biological graft materials for stress urinary  
4 incontinence.

5 Q. Those aren't available anymore, though,  
6 as I understand it?

7 A. That's correct.

8 Q. And the autologous sling procedure that  
9 you do --

10 A. Yes, sir.

11 Q. -- do you counsel the patients that  
12 there is a risk of dyspareunia or pain with intercourse  
13 as a potential complication of that procedure?

14 A. I do.

15 Q. And is part of the reason for that that  
16 you actually have to, I guess, make an incision through  
17 the vagina?

18 A. Yes, sir.

19 Q. And any time you do that, there's the  
20 potential for dyspareunia or pain with intercourse,  
21 correct?

22 A. That's true.

23 Q. And I guess even Burch procedures, they  
24 could lead to dyspareunia and pelvic pain as well,

1 correct?

2 A. That's correct.

3 Q. Any time you're operating in the vaginal  
4 vault, you would have to counsel the patient about the  
5 potential for dyspareunia or pain with intercourse,  
6 true?

7 A. This is true.

8 Q. And even if Ms. Martin had come to you  
9 for an autologous sling procedure, you would have  
10 counseled her that there was a risk of dyspareunia,  
11 true?

12 A. I would have counseled her towards the  
13 differences between mesh and the autologous fascial  
14 sling with regards to every complication, indeed.

15 Q. You would have laid out the options for  
16 the two procedures, true?

17 A. That's correct.

18 Q. And if she selected the autologous  
19 procedure, you would have counseled her that there is a  
20 risk of dyspareunia with that procedure, true?

21 A. And less so with mesh, but, yes, true.

22 Q. So even if Ms. Martin had had an  
23 autologous sling procedure, there's the potential for  
24 pain with sex, true?

1 MR. THOMPSON: Object to form.

2 THE WITNESS: That's a fair comment.

3 BY MR. GRIFFIN:

4 Q. And I guess scarring is also a risk with  
5 the sling -- with the autologous sling procedure where  
6 you've made your incision, true?

7 A. Correct.

8 Q. Is it fair to say that the complication  
9 Ms. Martin has regarding painful intercourse is a  
10 potential complication of the nonmesh surgeries that  
11 are used to treat stress urinary incontinence as well?

12 A. I don't know if I can answer that  
13 question, as she has not had any nonmesh based  
14 anti-incontinence procedure.

15 Q. I guess what I'm saying is every one of  
16 the -- other than collagen, but any of the surgical  
17 procedures that the patient might have for stress  
18 urinary incontinence had the potential complication of  
19 painful intercourse, correct?

20 A. This is true.

21 Q. So even if she had a nonmesh procedure,  
22 she faced that potential complication, that being  
23 painful intercourse, correct?

24 A. This is correct.

1 Q. In fact, the Burch procedure suggested  
2 by Dr. Miklos carried the risk of dyspareunia as well  
3 and pelvic pain, correct?

4 A. I believe he actually wrote the number  
5 in his consent.

6 Q. The percentages?

7 A. It was very low, less than 1%, I think  
8 he said.

9 Q. That was -- that clearly looked like it  
10 was based on his experience?

11 A. That's correct.

12 Q. Is that how you looked at it?

13 A. That's how I looked at it, and that's  
14 roughly an appropriate quote for the standard  
15 urologist, urogynecological surgeon.

16 Q. There's no way that you could say more  
17 probably than not that any removal of additional mesh  
18 would change the picture of her dyspareunia, correct?

19 MR. THOMPSON: Object to the form.

20 THE WITNESS: It's possible it might  
21 help.

22 BY MR. GRIFFIN:

23 Q. But there's no way for you to say more  
24 probably than not that it would, true?

1 MR. THOMPSON: Object to the form.

2 THE WITNESS: It's hard for me to make  
3 that -- to formulate that opinion.

4 BY MR. GRIFFIN:

5 Q. It's impossible at this point, true?

6 MR. THOMPSON: Object to the form.

7 THE WITNESS: I think I said possibly  
8 before, so I guess I don't want to conflict  
9 what I just said before.

10 BY MR. GRIFFIN:

11 Q. Okay. There's no way for you to say  
12 more probably than not that removal of additional mesh  
13 would improve Ms. Martin's dyspareunia, correct?

14 MR. THOMPSON: Object to the form, asked  
15 and answered.

16 THE WITNESS: The only way to really  
17 answer that question would be to remove the  
18 additional mesh and formulate that decision or  
19 opinion.

20 BY MR. GRIFFIN:

21 Q. So the answer is no?

22 MR. THOMPSON: Object to the form.

23 THE WITNESS: I can't answer that  
24 question as it's asked.

1 BY MR. GRIFFIN:

2 Q. Okay. Is there any way you can say more  
3 probably than not that additional mesh removal would  
4 improve Ms. Martin's dyspareunia?

5 A. It might help.

6 Q. Can you say more probably than not that  
7 it would?

8 A. As my report states, they might be  
9 helped.

10 Q. And my question is can you say more  
11 probably than not that it would help?

12 MR. THOMPSON: Object to the form.

13 THE WITNESS: You know the problem with  
14 answering that question is that I guess, first  
15 off, each patient is unique, so it's kind of  
16 like asking if someone is pregnant, you know,  
17 either you are or you're not, right.

18 For me to answer that question can only  
19 be determined by doing it and seeing it, and  
20 the reason I answer it like that is because  
21 with each additional surgery she has, there  
22 will be more fibrosis and more scarring.

23 For example, with Dr. Marinis' surgery  
24 where he targeted her dyspareunia as being

1                   anterior vaginal related to the sling and then  
2                   over the next six months she has differing  
3                   opinions and then sees me three years later  
4                   and, lo and behold, at least on my examination,  
5                   her pain is more anterior vaginal wall located.  
6                   It's hard to say if additional mesh removal may  
7                   help because in so doing, one might be removing  
8                   the offending agent but in the process creating  
9                   more scar tissue, and that's why I'm not trying  
10                  to be difficult, but that's why it's hard for  
11                  me to answer your question.

12 BY MR. GRIFFIN:

13 Q.           We do know that removal of the TVT mesh  
14 did not cure her dyspareunia, did it?

15 A.           Well, we're not clear on that.

16 Q.           The procedure that Dr. Marinis did did  
17 not cure her dyspareunia, correct?

18 A.           Not ultimately, it did not.

19 Q.           And I guess there's no way for you to  
20 say whether the vestibulectomy or the perineoplasty  
21 recommended by Dr. Peacock and Dr. Miklos would or  
22 would not help her dyspareunia, true?

23 MR. THOMPSON: Object to the form.

24 THE WITNESS: I would agree with that

1 question.

2 BY MR. GRIFFIN:

3 Q. It may or may not -- those procedures  
4 may or may not help her dyspareunia would be your  
5 response, true?

6 A. They might help it somewhat.

7 Q. So in addition to what you identified as  
8 a potential reason for her dyspareunia, you would agree  
9 with me that other potential causes exist, including  
10 vestibulitis, the potential need for perineoplasty and  
11 vaginal atrophy, true?

12 MR. THOMPSON: Object to the form.

13 THE WITNESS: I would not agree with  
14 that wholeheartedly, no.

15 BY MR. GRIFFIN:

16 Q. Halfheartedly?

17 A. About one-third-heartedly.

18 Q. Okay.

19 A. No, the reason I say that, not to be  
20 cheeky, is because I have no evidence based on my  
21 clinical exam and history taking that vestibulitis is  
22 part of this problem. Inasmuch as vulvovaginal atrophy  
23 might be part of this problem, her dyspareunia seems to  
24 both precede that diagnosis and seems to be persisting

1       despite the adequate treatment of that diagnosis.

2           Q.        Okay. So the vaginal atrophy, at least  
3       according to Dr. Peacock's records, might be a partial  
4       cause, you would give it that, correct, for  
5       dyspareunia?

6           A.        Inasmuch as in 2016 she hasn't had sex  
7       in three years, despite that therapy, I'm hard pressed  
8       to imagine it being a real significant issue for her.

9           Q.        Did you check to see -- one of the  
10      things you pointed out was that due to the  
11      contractions, the trabeculations occurred in the  
12      bladder itself, true?

13          A.        That was pointed out by Dr. Marinis.

14          Q.        And did you do a cystoscopy to determine  
15      whether they still existed or not?

16          A.        I did not.

17          Q.        They should still exist, though, if you  
18      do a cystoscopy, correct?

19          A.        To some degree you should see some  
20      findings.

21          Q.        Did you look for subsequent cystoscopies  
22      to see if, in fact, there was evidence of that?

23          A.        I think she may have had a cystoscopy by  
24      Dr. Peacock, but I don't recall that.

1 Q. And Dr. Peacock, in fact, found no  
2 evidence of trabeculations based on her examination,  
3 did she?

4 A. Probably, if it would be okay, I'd like  
5 to see those records, just to refresh my memory.

6 There's no comment made towards the  
7 presence of trabeculations.

8 Q. So they do not appear in 2012 after  
9 Dr. Marinis saw them apparently in 2011?

10 MR. THOMPSON: Object to the form.

11 THE WITNESS: Interestingly enough,  
12 there's no comment made to that effect in  
13 Dr. Peacock's notes.

14 MR. GRIFFIN: I will reserve any  
15 remaining time.

16 BY MR. THOMPSON:

17 Q. Doctor, let me ask you just a couple of  
18 questions. You've had an opportunity to look at --  
19 you've been confronted with and had an opportunity to  
20 look at Dr. Peacock's notes?

21 A. Yes, sir.

22 Q. Also, you've had a chance to review  
23 Dr. Miklos and you've been reminded of Dr. Hill's  
24 deposition.

1                   Do any of the facts that are contained  
2 within those records or reports alter your opinions  
3 that you've rendered previously in this case?

4                   A.       They do not.

5                   Q.       Doctor, your -- to the extent that you  
6 are examining Ms. Martin in 2016 personally, do you  
7 give the IME more weight or do you -- strike that.

8                   Do you view the medical records from the  
9 perspective of having given a IME and given a personal  
10 physical examination of Ms. Martin?

11                  MR. GRIFFIN: Object to form.

12                  THE WITNESS: I do.

13 BY MR. THOMPSON:

14                  Q.       To the extent that various doctors have  
15 identified various locations of pain within the vagina  
16 of Ms. Martin, we can all be -- we can all agree that  
17 she only has one vagina, right?

18                  A.       I would hope so, yes.

19                  Q.       And would you agree that the pain that  
20 she evidenced to you in 2016 was related to the site of  
21 the mesh?

22                  MR. GRIFFIN: Object to form of the  
23 question.

24                  THE WITNESS: Yes.

1 BY MR. THOMPSON:

2 Q. Doctor, I notice in your report that you  
3 give the opinion -- that you sign the opinion -- I need  
4 to ask you one more question, are the opinions that you  
5 express within this report rendered within your  
6 expertise to a reasonable degree of medical certainty?

7 A. Yes.

8 MR. THOMPSON: Mr. Griffin, that's all  
9 I'm going to ask.

10 BY MR. GRIFFIN:

11 Q. You indicated that none of your opinions  
12 changed despite the fact that you had reviewed now or  
13 been back through the records of Dr. Peacock,  
14 Dr. Miklos and Dr. Hill's testimony, correct?

15 A. Yes, sir.

16 Q. Is one of those opinions excluding  
17 periurethral banding?

18 A. It is, yes.

19 Q. What is periurethral banding?

20 A. Periurethral banding describes a  
21 condition where usually in the presence of mesh, there  
22 can be a palpable band of tissue that neither expands  
23 and has essentially a feeling of a palpable scar, that  
24 can be a source of dyspareunia. It's sometimes

1 described banding as well as just the presence of scar  
2 tissue per se, but, classically, that's described as a  
3 palpable band that one feels, where there is a scar  
4 plate and mesh together.

5 Q. And you did not find that in this  
6 patient, true?

7 A. No, there was no -- her mesh had been  
8 removed, so I didn't formulate that finding.

9 Q. You were not able to palpate any mesh,  
10 true?

11 A. Not necessarily true.

12 Q. Did you feel any?

13 A. Well, as we discussed, that area in that  
14 left vaginal sulcus very well could have mesh behind it  
15 or underneath it, but there was such thick scar that I  
16 really can't make a definitive comment that there's  
17 mesh there.

18 Q. Did you find any erosion, exposure or  
19 anything of mesh during your examination?

20 A. I did not.

21 Q. You also state in here that you were  
22 able to exclude vestibulitis as a cause for  
23 Ms. Martin's vaginal pain and dyspareunia because  
24 there's no evidence in the medical records of the

1 presence of this condition.

2 Do you want to take that back now?

3 A. Well, I think if you look at my report,  
4 what you'll actually see is that Dr. Peacock's notes  
5 were not part of my review.

6 Q. Okay. So now that you've had a chance  
7 to review Dr. Peacock's records, do you want to take  
8 that back?

9 A. I would modify that sentence. I would  
10 still exclude it, but I would exclude it having  
11 respectfully reviewed and perhaps refuted Dr. Peacock's  
12 findings.

13 Q. You would exclude it based upon what you  
14 found in 2016, true?

15 A. Certainly, that's true, yes.

16 Q. But you would not necessarily exclude it  
17 that that may have been the cause of her dyspareunia in  
18 2012 because you didn't have an opportunity to examine  
19 her at that time; would that be fair?

20 A. I would probably agree on the basis  
21 saying one of the causes of her dyspareunia. I think  
22 it's fair to discuss that as part of the differential.

23 Q. So one of the causes of her dyspareunia  
24 in 2012 was the vestibulitis, true?

1 A. Possibly.

2 Q. Okay. And one of the causes of her  
3 dyspareunia in 2012 may have been her need for  
4 perineoplasty, true?

5 A. That's what Dr. Miklos had opined.

6 Q. True?

7 A. I think that's part of it, possibly.

8 Q. Those diagnosis were made by  
9 urogynecologists?

10 A. Yes.

11 Q. Just so I know, are you -- you're a  
12 gynecologist, true?

13 A. No, I'm a urologist.

14 Q. You're a urologist?

15 A. Yes, sir.

16 Q. Are there urogynecologists in your  
17 group?

18 A. Yes. Well, there's one urogynecologist  
19 in my group, yes.

20 Q. What training do urogynecologists have  
21 that urologists don't or vice versa?

22 A. The difference between the two  
23 specialities is that a urogynecologist completes a  
24 formal residency in obstetrics and gynecology and then

1 does anywhere from a two to three-year fellowship in  
2 urogynecology. Whereas urologists typically complete a  
3 five to six-year residency involving both general  
4 surgery and urology and then embark on what's called a  
5 female urology fellowship, which can be anywhere from  
6 one to three years, depending upon academic, research,  
7 clinical work, et cetera.

8 MR. GRIFFIN: I don't have any other  
9 questions.

10 MR. THOMPSON: Thank you. I don't have  
11 any redirect.

12 (Witness excused.)

13 (Deposition concluded at 10:48 a.m.)

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C E R T I F I C A T I O N

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I, MARGARET M. REIHL, a Registered

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Professional Reporter, Certified Realtime

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Reporter, Certified Shorthand Reporter,

5

Certified LiveNote Reporter and Notary Public,

6

do hereby certify that the foregoing is a true

7

and accurate transcript of the testimony as

8

taken stenographically by and before me at the

9

time, place, and on the date hereinbefore set

10

forth.

11

I DO FURTHER CERTIFY that I am

12

neither a relative nor employee nor attorney

13

nor counsel of any of the parties to this

14

action, and that I am neither a relative nor

15

employee of such attorney or counsel, and that

16

I am not financially interested in the action.

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Margaret M. Reihl, RPR, CRR, CLR

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CSR #XI01497 Notary Public

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ACKNOWLEDGMENT OF DEPONENT

2

3 I, KONSTANTIN WALMSLEY, M.D., do hereby  
4 certify that I have read the foregoing pages,  
5 and that the same is a correct transcription of  
6 the answers given by me to the questions  
7 therein propounded, except for the corrections  
8 or changes in form or substance, if any, noted  
9 in the attached Errata Sheet.

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KONSTANTIN WALMSLEY, M.D.

DATE

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15

Subscribed and sworn to before me this

16

\_\_\_\_\_ day of \_\_\_\_\_, 2016.

17

My commission expires: \_\_\_\_\_

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Notary Public

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